Optional Group Life Insurance Plan

- Employees actively employed at half-time or more and who are already enrolled in the Basic Group Life Insurance are eligible to enroll in the Optional Group Life Insurance plan.

- The optional life insurance is available in units of $25,000 (minimum $25,000, maximum $500,000). The amount of accidental death and dismemberment insurance will be limited to the amount of your optional life insurance selected.

- If applying for coverage ensure all forms in the package are completed (enrolment form, authorization and application) and signed.

University of Victoria #40703
Optional Group Life Insurance Monthly Premium
Employee and Spouse (note: Spouse rate based on Employee Age)

ns = non-smoker, s = smoker

July 1, 2021 RENEWAL

$	to age 34		age 35-39		age 40-44		age 45-49		age 50-54		age 55-59		age 60-64		age 65-69		age 70	
	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s	ns	s
25,000	0.48	1.00	0.70	1.25	0.93	1.88	1.70	3.48	3.38	6.85	5.85	11.95	10.38	20.65	15.70	31.53	21.58	43.08
50,000	0.95	2.00	1.40	2.50	1.85	3.75	3.40	6.95	6.75	13.70	11.70	23.90	20.75	41.30	31.40	63.05	43.15	86.15
75,000	1.43	3.00	2.10	3.75	2.78	5.63	5.10	10.43	10.13	20.55	17.55	35.85	31.13	61.95	47.10	94.58	64.73	129.23
100,000	1.90	4.00	2.80	5.00	3.70	7.50	6.80	13.90	13.50	27.40	23.40	47.80	41.50	82.60	62.80	126.10	86.30	172.30
125,000	2.38	5.00	3.50	6.25	4.63	9.38	8.50	17.38	16.88	34.25	29.25	59.75	51.88	103.25	78.50	157.63	107.88	215.38
150,000	2.85	6.00	4.20	7.50	5.55	11.25	10.20	20.85	20.25	41.10	35.10	71.70	62.25	123.90	94.20	189.15	129.45	258.45
175,000	3.33	7.00	4.90	8.75	6.48	13.13	11.90	24.33	23.63	47.95	40.95	83.65	72.63	144.55	109.90	220.68	151.03	301.53
200,000	3.80	8.00	5.60	10.00	7.40	15.00	13.60	27.80	27.00	54.80	46.80	95.60	83.00	165.20	125.60	252.20	172.60	344.60
225,000	4.28	9.00	6.30	11.25	8.33	16.88	15.30	31.28	30.38	61.65	52.65	107.55	93.38	185.85	141.30	283.73	194.18	387.68
250,000	4.75	10.00	7.00	12.50	9.25	18.75	17.00	34.75	33.75	68.50	58.50	119.50	103.75	206.50	157.00	315.25	215.75	430.75
275,000	5.23	11.00	7.70	13.75	10.18	20.63	18.70	38.23	37.13	75.35	64.35	131.45	114.13	227.15	172.70	346.78	237.33	473.83
300,000	5.70	12.00	8.40	15.00	11.10	22.50	20.40	41.70	40.50	82.20	70.20	143.40	124.50	247.80	188.40	378.30	258.90	516.90
325,000	6.18	13.00	9.10	16.25	12.03	24.38	22.10	45.18	43.88	89.05	76.05	155.35	134.88	268.45	204.10	409.83	280.48	559.98
350,000	6.65	14.00	9.80	17.50	12.95	26.25	23.80	48.65	47.25	95.90	81.90	167.30	145.25	289.10	219.80	441.35	302.05	603.05
375,000	7.13	15.00	10.50	18.75	13.88	28.13	25.50	52.13	50.63	102.75	87.75	179.25	155.63	309.75	235.50	472.88	323.63	646.13
400,000	7.60	16.00	11.20	20.00	14.80	30.00	27.20	55.60	54.00	109.60	93.60	191.20	166.00	330.40	251.20	504.40	345.20	689.20
425,000	8.08	17.00	11.90	21.25	15.73	31.88	28.90	59.08	57.38	116.45	99.45	203.15	176.38	351.05	266.90	535.93	366.78	732.28
450,000	8.55	18.00	12.60	22.50	16.65	33.75	30.60	62.55	60.75	123.30	105.30	215.10	186.75	371.70	282.60	567.45	388.35	775.35
475,000	9.03	19.00	13.30	23.75	17.58	35.63	32.30	66.03	64.13	130.15	111.15	227.05	197.13	392.35	298.30	598.98	409.93	818.43
500,000	9.50	20.00	14.00	25.00	18.50	37.50	34.00	69.50	67.50	137.00	117.00	239.00	207.50	413.00	314.00	630.50	431.50	861.50

Optional Group Accidental Death and Dismemberment Inusrance Monthly Premium

Coverage	25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000
Monthly Premium	.75	1.50	2.25	3.00	3.75	4.50	5.25	6.00	6.75	7.50

To: ***Human Resources***
University of Victoria

For coverage, please complete the enrolment form on the reverse side and forward

Termination of Insurance

Your insurance will cease on the earliest of the following events:

- the date your employment is terminated
- your normal or deferred retirement date, to age 71
- the last day of the last month for which a premium has been paid, subject to the total disability provisions of the group policy
- the date the group policy is terminated

The insurance on your spouse and dependent child will cease on the earliest of the following events:

- the date your employment is terminated
- the date the dependent ceases to qualify under the definition of dependent
- your normal or deferred retirement date, to age 71
- the last day of the last month for which a premium has been paid for your dependent insurance, subject to the total disability provisions of the group policy
- the date the group policy is terminated

Conversion Privilege

If your insurance terminates or reduces for any reason other than solely as a result of your request, you are entitled to a conversion privilege which entitles you to purchase an individual life policy from Blue Cross Life Insurance Company of Canada without undergoing any medical examination. A conversion privilege is also available to your spouse. Conversion privilege is only available up to the normal retirement date.

Making a Claim

If you or any of your insured dependents die, a claim should be made as soon as reasonably possible.

If you become totally disabled or suffer any other loss, a claim should be made not later than 12 months after the onset of the Total Disability or the date of loss.

General Information

This plan provides for premium payment through convenient payroll deduction. The premium you pay is competitive since the insurance is offered on a group basis.

Premium rate changes due to a change between age brackets will occur on your birthday.

This brochure is for information purposes only. Coverage under the plan is governed by the terms of the Optional Group Insurance policy issued by British Columbia Life & Casualty Company.

0034.005 60-15-510 09/15 CUPE 1816

Optional Group Life Insurance Plans

for eligible UVIC faculty and staff

University of Victoria

Underwritten by
BC Life & Casualty Company

Optional Group Life Insurance Plan

This plan provides you with an opportunity to purchase optional group life insurance additional to your basic group life coverage. This insurance is payable in the event of your death from any cause while in the University's employment other than from suicide within two years from the effective date of your insurance.

Optional Group Accidental Death and Dismemberment (AD&D)

This Plan provides you with an opportunity to purchase optional AD&D insurance along with optional group life coverage. This insurance is payable in the event of your accidental death or dismemberment.

Loss of life	*100%*
Loss of both arms or legs	*100%*
Loss of use of one arm or one leg	*75%*
Loss of both hands or both feet	*100%*
Loss of one hand or one foots	*66 2/3%*
Loss of use of one hand or one foot	*66 2/3%*
Loss of entire sight in both eyes	*100%*
Loss of speech	*50%*
Loss of hearing in both ears	*50%*

For example, if, while insured, you sustain accidental bodily injury which results directly and independently of all other causes in one of the losses listed below within 365 days after the injury, BC Life & Casualty Company will pay a benefit as follows (partial list). A schedule of available coverage and the corresponding premium you pay appears below.

No more than 100% of the amount of Optional Group AD&D is payable for all losses due to any one accident.

There are exclusions for which a benefit is not paid relating to suicide, drug overdose, specific aircraft hazards and hostile actions of any armed forces.

Spouse Optional Group Life Insurance Plan

This plan provides you with an opportunity to purchase optional group life insurance for your spouse on the same terms as applicable to you.

A person will qualify as a spouse by virtue of a legal marriage or by being publicly represented as your spouse for a period of at least one year.

This insurance is payable in the event of the death of your spouse from any cause while your coverage remains in force, other than from suicide within two years from the effective date of the insurance.

Amount of Coverage Available

The insurance is available in units of $25,000 (minimum $25,000, maximum $500,000). A schedule of available coverage and the corresponding premium you pay appears below. The amount of accidental death and dismemberment insurance will be limited to the amount of your optional life insurance selected. The additional premium for this benefit also appears below.

Dependent Child Group Life Insurance

$5,000 of child coverage for each eligible dependent child from birth to age 21 (age 25 if a full-time student) will be automatically provided at no extra charge when either employee or spouse optional life insurance is elected. A handicapped child who attains the limiting age may continue coverage as a Dependent if proof of the handicap is received within 31 days after the child attains the limiting age.

This insurance is payable in the event of the death of your dependent child from any cause while coverage is in force, other than from suicide within two years from the effective date of the insurance.

Joining the Plan

You are eligible to join this plan if you are enrolled in the University's basic life insurance program.

New employees and/or their spouses may join the plan subject to providing evidence of insurability satisfactory to BC Life & Casualty Company. Coverage will take effect on the date of approval of the evidence provided you are actively at work. Dependent coverage will take effect on the date of approval of the evidence, provided the dependent is not confined in a hospital or similar institution on that date and you are actively at work.

The Completed Enrolment Form and Health Questionnaire Must Be Forwarded to Human Resources.

When you and/or your spouse enrol you must name the beneficiary to whom benefits would be payable. You may change the beneficiary at anytime subject to any legal restriction which may affect this right by filing a change of beneficiary form with Human Resources. If there is no named living beneficiary, benefits would be paid to your Estate. If children are covered, their benefit will be paid to you, if living, otherwise to your estate.

Changes

Evidence of insurability satisfactory to BC Life & Casualty Company will be required for any increase or addition.

You may increase your employee and/or your spouse's life insurance or your AD&D coverage at any time up to the allowable limit if you and/or your spouse provide evidence of insurability satisfactory to BC Life & Casualty Company.

You may decrease your insurance coverage at any time.

A change in coverage becomes effective on the date evidence of insurability is approved by BC Life & Casualty Company. (Evidence of Insurability forms are available from Human Resources.) In addition, if you are not actively at work on the effective date of change in coverage, you and/or your Dependent's coverage is delayed until you are actively at work. Similarly, Dependent insurance is delayed until discharge for a Dependent who is in a hospital or similar institution.

All changes are subject to the maximum available coverage under this policy.

Total Disability

If you become totally disabled while covered by the plan and before attaining normal or earlier retirement, you and/or your dependent's optional life insurance coverage will remain in force without payment of premium as long as you continue to be totally disabled and provided proof of total disability is furnished as required by BC Life & Casualty Company. The insurance company may also require proof of age.

UNIVERSITY OF VICTORIA BC Life Policy
Employees' and Spouses' Optional Group Insurance **ENROLMENT FORM**

EMPLOYEE family name, first name, initials | ID Number | Date of Birth: Day / Month / Year

SPOUSE family name, first name, initials (if spouse insurance is applied for) | Date of Birth: Day / Month / Year

Have you or your spouse used tobacco products during the 12 month period immediately preceding the date written below beside your signature? Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

I apply for Optional Life Insurance for – myself in the amount of $ ____ Multiples of $25,000 to $500,000 ☐ Smoker. ☐ Non Smoker. FOR OFFICE USE ONLY

I apply for Optional Spouse Life Insurance – for my Spouse in the amount of $ ____ Multiples of $25,000 to $500,000 ☐ Smoker. ☐ Non Smoker. FOR OFFICE USE ONLY

I apply for Accidental Death and Dismemberment for myself in the amount of $ ____ Multiples of $25,000 to $500,000 ☐ Smoker ☐ Non Smoker FOR OFFICE USE ONLY

EMPLOYEE OPTIONAL GROUP LIFE (and Accidental Death, if any) **REVOCABLE BENEFICIARY NOMINATION**

beneficiary's family name, given name, relationship to employee

I hereby nominate the above beneficiary if living, otherwise to my estate, to receive any amount due on my death while insured under this group policy. I reserve the right to change the beneficiary appointed above subject to any statutory regulations.

SPOUSE OPTIONAL GROUP LIFE

beneficiary's family name, given name, relationship to employee

I hereby nominate the above beneficiary if living, otherwise myself (the employee) to receive any amount due on my spouse's death while insured under this group policy. I reserve the right to change the beneficiary appointed above subject to any statutory regulations.
Children's benefits will be payable to myself (the employee).

Signature of Employee _____ Date _____ Signature of Spouse _____
I authorize my employer to deduct from my pay amounts required according to choice of coverage.

NOTE: Your spouse must sign this application if spouse's coverage is being applied for.

PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

STATEMENT OF HEALTH

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | 604 419-2000 or Toll Free 1 877 PAC-BLUE | Fax: 604 419-2149

APPLICANTS — Please complete PART 2-7 of this application and return to enrollment@pac.bluecross.ca.
If applying for Optional Life coverage, please also complete a Beneficiary Designation form.
EMPLOYERS/PLAN ADMINISTRATORS — Please complete PART 1 of this application.

PART 1 — EMPLOYER/PLAN ADMINISTRATOR

Policy number	Name of company/organization	Member ID number	Date of hire/rehire (mm-dd-yyyy)
40703	University of Victoria		

Reason for application
☐ Late enrollment ■ Increase coverage ☐ Annual re-enrollment

Who is this application for
☐ Member ☐ Spouse ☐ Dependent(s)

Type of insurance and amount applying for

☐ Life/Accidental death & dismemberment $ _____
☐ Dependent life $ n/a
☐ Extended health care
☐ Dental
☐ Short-term disability $ n/a
☐ Long-term disability $ n/a
☐ Critical illness $ n/a
☐ Member Optional Life $ _____
☐ Spouse Optional Life $ _____
☐ Member Optional Critical Illness $ n/a
☐ Spouse Optional Critical Illness $ n/a

PART 2 — APPLICANT INFORMATION

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
				☐F ☐M ☐U ☐X

Country of birth	Occupation	Height	Weight

Address	City	Province	Postal code

Email	Phone number	Fax

Physician and medical records

Please select one of the following and complete the details below accordingly
☐ Below is my primary physician's information ☐ I don't have a primary physician, but the clinic below has my records

Physician's first name	Physician's last name	Clinic name

Address	City	Province	Postal code

Email	Phone number	Fax

PART 3 — ADDITIONAL INDIVIDUALS TO BE COVERED

Only fill out part 3 if there are additional individuals that you are applying for.

Spousal information

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Height	Weight

Dependent(s) information

Dependent 1

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
n/a				☐F ☐M ☐U ☐X

Dependent 2

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
n/a				☐F ☐M ☐U ☐X

Dependent 3

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
n/a				☐F ☐M ☐U ☐X

Dependent 4

Legal first name	Middle initial	Last name	Birthdate (mm-dd-yyyy)	Gender*
n/a				☐F ☐M ☐U ☐X

*F = Female, M = Male, U = Prefer not to disclose, X = Another gender

PART 4 — GENERAL DECLARATION

	MEMBER	SPOUSE
1. Have you or your spouse used any form of tobacco, tobacco cessation products, nicotine, e-cigarettes, or nicotine replacement products in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide details (Member) _____		
If yes, provide details (Spouse) _____		
2. Has your weight decreased more than 4.5 kg or 10 lbs in the past year?	☐ Yes ☐ No	☐ Yes ☐ No

	If yes, how much weight was lost?	Reason(s) for weight loss
Member		
Spouse		

3. Have you or your dependents ever applied for or received benefits, compensation, or pension due to injury or disability? If yes, provide details.	☐ Yes ☐ No	☐ Yes ☐ No
If yes, provide details (Member) _____		
If yes, provide details (Spouse) _____		

Dependents

Fill this out if this applies to 1 or more of your dependents. You do not need to identify which dependent.

☐ Yes ■ No

If yes, provide details n/a

PART 5 — MEDICAL DECLARATION

5.1 Have you, your spouse or dependent(s) consulted a physician, been treated for or have/had any known indication of any of the following medical conditions? If you are unsure how to answer any of these questions, please consult your doctor.

If you answer yes to any section in question 5.1 and/or 5.2, please complete question 5.4.

	MEMBER (YOU)	SPOUSE	DEPENDENT(S)
a) **Cardiovascular or circulatory** including vascular disease, high blood pressure, elevated cholesterol, heart attack, angina, stroke or TIA (mini-stroke) and blood disorders.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) **Diabetes / Endocrine disorders** including Type 1 or Type 2, hormonal or thyroid conditions.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) **Gastrointestinal conditions** including stomach, intestinal or liver conditions (including hepatitis A, B, C or B carrier state), Colitis, Crohn's disease, Irritable Bowel Syndrome, Diverticulitis, Colon polyps, Ulcers, Hernia, GERD (acid reflux or persistent heartburn).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) **Respiratory or Lung conditions** including Allergies, Asthma, Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) **Musculoskeletal conditions** including Osteoarthritis or Rheumatoid Arthritis, Osteoporosis, bone density loss or back, neck, limb or joint pain (including Fibromyalgia).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) **Immunological conditions** including being tested for, counselled for, treated for or told you have AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus) or any other immunological disorder.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) **Genitourinary conditions** including kidney, bladder, infertility or Reproductive Disorders, Menopause, Endometriosis, Sexually Transmitted Disease(s) or recurring infections (cold sore/ Herpes/Shingles).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) **Neurological conditions** including Alzheimer's, Dementia, Parkinson's, epilepsy, Multiple Sclerosis, Seizures, Paralysis, chronic headaches or migraines, or Chronic Fatigue Syndrome.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) **Mental or Nervous conditions** including Anxiety, Depression, Emotional Disorders, Eating Disorders, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) **Cancer and Tumors** including malignant or benign, leukemia.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) **Drugs** including ever used narcotics, stimulants, hallucinogens or other drugs except those that were prescribed by a physician.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PART 5 — MEDICAL DECLARATION (continued)

	MEMBER (YOU)	SPOUSE	DEPENDENT(S)
5.2 Within the past five years, have you had any medical conditions not already mentioned on this form or abnormal test results?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.3 Do you currently have a referral, testing, treatment or investigation pending or contemplated but not yet completed, or are you aware of any symptoms or problems that require medical attention? If yes, provide details ____________	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.4 If you answered YES to any part of question 5.1 and/or 5.2, please provide details. Please use one section per condition/disorder, even if an individual has multiple conditions/disorders.			

Name of individual	Diagnosis date (mm-dd-yyyy)	☐ Same physician as in part 2.3	
Condition/disorder		Physician name	
Medication/treatment		Address	
Recovery date (mm-dd-yyyy)		Email	Phone number

Name of individual	Diagnosis date (mm-dd-yyyy)	☐ Same physician as in part 2.3	
Condition/disorder		Physician name	
Medication/treatment		Address	
Recovery date (mm-dd-yyyy)		Email	Phone number

Name of individual	Diagnosis date (mm-dd-yyyy)	☐ Same physician as in part 2.3	
Condition/disorder		Physician name	
Medication/treatment		Address	
Recovery date (mm-dd-yyyy)		Email	Phone number

If there aren't enough sections in 5.4, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), conditions/disorders, diagnosis date, medication/treatment, and physician information.

____

____

5.5 Are you, your spouse or dependents taking any other prescribed medication(s) that you have NOT already disclosed above? If yes, provide name of medication(s) and reason below. Please use one section per individual, even if the individual is using multiple medications.

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

Name of individual	Medication(s)
Dosage	Frequency
Reason(s) for medication	

PART 5 — MEDICAL DECLARATION (continued)

If there aren't enough sections in 5.5, please add details to the box below. Include the name of the individual (i.e., your name, spouse, or a dependent), name of medication(s), dosage, frequency and reason(s) for medication.

5.6 Please identify any biological parents or siblings of yourself and/or your spouse who before the age 60, have ever had cancer, heart or kidney disease, mental or nervous disorder or any inheritable disorder (such as Huntington's chorea or polycystic kidney disease).

INDIVIDUAL	DETAILS OF THE CONDITION
Member's parent 1	
Member's parent 2	
Member's sibling	
Member's sibling	
Spouse's parent 1	
Spouse's parent 2	
Spouse's sibling	
Spouse's sibling	

PART 6 — DECLARATION AND AUTHORIZATION

I, the undersigned, declare that the answers to the above questions and the questions on the reverse of this form are complete and accurate and form part of an application for coverage with Blue Cross Life Insurance Company of Canada (Blue Cross Life) and/or Pacific Blue Cross. The information provided herein and collected in the future as part of the application process will be kept confidential and secure. This information will be used to determine eligibility for coverage, to administer the terms of my policy, to recommend suitable products and services to me and to manage the company's business. For these purposes, I (i) authorize any physician, health practitioner, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, government or regulatory authority, the MIB, LLC, or other organization, institute or person, that has any records or knowledge of me/my child or my/their health, to give Blue Cross Life, Pacific Blue Cross or their reinsurer any such information and (ii) Blue Cross Life and Pacific Blue Cross to access and use relevant information in records that they already hold about me.

I further authorize Blue Cross Life and Pacific Blue Cross to disclose this information to each other, their reinsurer or to any third party when required to determine eligibility of the application. Medical information may also be released to my/my child's personal physician or other medical practitioner. I have received and read the enclosed notice form describing the procedures of the MIB, LLC. I authorize Blue Cross Life and/or Pacific Blue Cross, or its reinsurer, to make a brief report of my personal health information to the MIB, LLC.

This consent is valid for as long as the contract is in force unless I revoke it in writing. I understand I may revoke my consent at any time; however, if consent is withheld or revoked the coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent. If I have questions about the collection, use or disclosure of my or my dependent's personal information, I can visit https://www.pac.bluecross.ca/privacy. A photocopy of this authorization shall be as valid as the original.

Member signature **X**	Date (mm-dd-yyyy)
Spouse signature **X**	Date (mm-dd-yyyy)

PART 7 — MIB, LLC PRE-NOTICE

IMPORTANT: Please read carefully.

Information regarding your insurability will be treated as confidential. Blue Cross Life Insurance Company of Canada or its reinsurers may, however, make a brief report thereon to MIB, LLC. which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB, LLC member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, LLC, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB, LLC. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB, LLC.'s files, you may contact the MIB, LLC and seek a correction. The address of the MIB LLC's information office is: MIB, LLC 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Telephone: 1 866 692-6901. www.mib.com

Blue Cross Life Insurance Company of Canada or their reinsurer may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

OPTIONAL GROUP LIFE INSURANCE
BC LIFE AND CASUALTY

Authorization

☐ I am applying for Optional Group Life Insurance and hereby authorize Human Resources to forward a *copy* of my Enrolment Form and the *original* Statement of Health to BC Life and Casualty Co. ***I have attached my original Group Life Enrolment and Statement of Health forms to this authorization***. I understand that this coverage will be implemented once BC Life and Casualty have approved my application.

_____ _____
Signature Date

or

☐ I am applying for Optional Group Life Insurance and have sent the *original* Statement of Health form and a *photocopy* of my Enrolment Form directly to BC Life and Casualty Co. ***I have attached my original Optional Group Life Enrolment form to this authorization***. I understand that this coverage will be implemented once BC Life and Casualty have approved my application.

_____ _____
Signature Date

Please return this signed form to the Benefits Office in Human Resources, along with the appropriate forms as outlined above.

UVic Optional Life FAQ

Timelines:

1. How long can I expect my application to take?
    a. Generally, PBC has committed to a 5-day turnaround for decision **once all of the required information is received**.
    b. Many applications do require additional information that may require input from your physician or further testing.
2. Why can the process take so long?
    a. As some applications may require additional medical information, the process may be delayed due to physician scheduling and testing requirements.
    b. Additional medical reports will be requested directly from your physician
    c. If testing is required, you will be informed directly and a representative from the Testing Facility will work with you to schedule the appropriate tests.
3. Who can I reach out to for an update on my application:
    a. Application updates can be requested by emailing medunderwriting@pac.bluecross.ca
4. Who can I contact to make general inquiries about applying for Optional Life coverage?
    a. Questions about optional life applications should be directed to your UVic Benefits Advisor.

Process:

1. Once PBC receives optional life application:
    a. PBC Member Administration confirms the Applicant's Evidence of Insurability (EOI)
        i. 10 business days to confirm eligibility
    b. Once confirmed, the application is sent to Medical Underwriting
    c. Initial review is completed within 5 days of receipt. This review will also determine if further medical information is required

2. If further medical is required?
    a. An email will be sent to the applicant informing of need for additional information
    b. If an attending physician statement is required:
        i. The Physician will be contacted directly. There will be no need for the Applicant to facilitate this request.
    c. If testing is required:
        i. A 3rd party medical testing facility will contact the applicant to arrange for the requisite tests.

Application Decisions:

1. Once a decision is made, PBC will send an email to the UVic Benefits Advisor.
    a. If approved
        i. An email will be sent to your UVic Benefits Advisor indicating an approved application
    b. If declined
        i. An email will be sent to your UVic Benefits Advisor indicating a declined application
        ii. A letter will also be sent to you indicating:
            1. Claim denial
            2. Reasons for denial
            3. Appeal options